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Nursing education: Efficacy of group teaching workshop for baccalaureate nursing students

Nathalie Eve Confiac

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NURSING EDUCATION:
EFFICACY OF GROUP TEACHING WORKSHOP
FOR BACCALAUREATE NURSING STUDENTS

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Science
in
Nursing

by
Nathalie Eve Confiac
March 2012
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ABSTRACT

Teaching is an essential role of nursing. Nonetheless nurse-led patient education has not been efficient. Research suggests that including a teaching component in undergraduate nursing program curricula could improve nurses teaching abilities and self-confidence. Yet, most undergraduate nursing curricula do not include principles of teaching and learning courses.

The purpose of this pilot study was to describe the impact of a group teaching preparation on Baccalaureate nursing students’ perceived knowledge, level of preparation and level of comfort regarding group teaching. Thirty-one students attended a four-hour workshop discussing basic group teaching skills and teaching strategies to be successful even in unexpected situations.

Surveys, pre- and post-tests were used the day of the workshop and after students completed their assignment to collect data about participants’ perceived knowledge, level of preparation and level of comfort regarding group teaching (n = 20). Additionally, participants provided feedback about the workshop.

The study was successful as seventy-six percent of the participants found it helpful. The participants’ perceived
knowledge increased after the workshop. Eighty-eight percent of the participants felt better prepared compared to 55% before the workshop and 94% felt comfortable in implementing their assignment. Participants reported learning and beginning to reflect on the elements to consider when teaching challenged clients. The study was also well received among the nursing faculty and provided an opportunity for a rich discussion about the topic in general and the possibility of including a teaching component in the BSN and RN to BSN programs’ future curricula.
ACKNOWLEDGEMENTS

This document is an illustration of my professional experience, convictions, nursing philosophy and strong advocacy for communities at large. Although it seems like a conclusion it is rather a stepping stone for further advanced nursing practice.

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- N405 Community/Public Health Nursing
- N401 Psych/Mental Health Nursing
- N220 Intermediate Nursing Process, Roles and Skills

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CHAPTER ONE
INTRODUCTION

Teaching is an essential role of nursing (Bastable, 2008), with healthcare trends progressing to patient self-care management (Bastable, 2008; Trocino, Byers & Peach, 1997). In previous literature, nurse-led patient education programs have been an essential component of disease management (Grossmann & Mahrer-Imhof, 2008). Khankeh, Rahgozar, and Ranjbar (2011) found patient and family group teaching and intervention by nurses encouraged psychiatric patients to participate in self-care and health, with potential for improved prognosis. Similarly, McCullough and Simon (2011) discussed the benefits of teaching interventions to siblings of children with developmental disabilities during support group sessions.

The impact of group teaching has been studied in public health setting as well: Sultemeier (1988) demonstrated that the use of group teaching as a method of instruction was more effective than one-to-one prenatal nutrition education in improving pregnant patients compliance with adequate food intake. Yet nurses often lack the required knowledge and skills to provide efficient
patient education particularly in group setting (Close, 1988; Delaney, 1994; Donner, Levonian, & Slutsky, 2005; Noble, 1991; Rowlands, 1987). Essential to fulfilling the role of nurse educator, then, is incorporation of teaching and learning principles into the undergraduate curriculum; in order to adequately prepare students for future professional functions.

Background

The importance of teaching as part of the nursing role is not a new concept. The National League for Nursing (NLN) previously known as the National League of Nursing Education, has acknowledged the importance of health teaching as early as 1917 in the Standard Curriculum for Schools of Nursing first published in 1917 then revised in 1927 and 1937 (Bastable, 2008; NLN, 1917, 1927, 1937). According to Bastable (2008), the NLN started to examine courses preparing nurses to teach others in 1950. Additionally the NLN developed the Core Competencies of Nurse Educators With Task Statements (NLN, 2005) and a certification for Nurse Educators in 2006 (Bastable, 2008; NLN, 2012).
Furthermore, the California Nursing Practice Act, Code of Regulations Title 16 and 22 clearly outlines the RN’s teaching role (Appendix A): The ability to teach clients and family how to take care of their health needs is a required skill to be considered as a competent Registered Nurse (RN)(16 CCR § 1443.5, 2010). The code of Regulations Title 16 and 22 also specify that the RN is responsible for developing, assessing, planning, implementing, and evaluating patients’ teaching plans (16 CCR § 1443.5, 2010; 22 CCR § 70215, 2010).

Theorists, such as Dorothy Orem, Florence Nightingale and Virginia Henderson have also addressed both patient and nursing education. In her metaparadigm concept, Dorothy Orem (1991) defines health as “being structurally and functionally whole and sound” (p. 96). Orem feels strongly about humans’ need to maintain optimum health and well-being (Self-care) and their ability and responsibility to self-care and care for their dependants (Self-care agency). In Dorothy Orem’s vision, nursing should (1) occur when a patient is unable to self-care; (2) be contingent to the degree of inability to self-care (Self-care deficit); and (3) involve the client active participation in his/her plan.
of care underscoring the importance of patient education (McEwen & Wills, 2011).

Florence Nightingale, writer, researcher and statistician is considered the founder of modern nursing (Bastable, 2008). Nightingale is best known for her work in the Scutari Army barracks during the Crimean war where her observations and statistical reporting methods improved the sanitary conditions of the military hospital leading to a decrease of wounded soldiers’ rate of deaths caused by infection (Nightingale & McDonald, 2009; McEwen & Wills, 2011). During that time Nightingale inherited the nickname of “the lady with the lamp” reflecting her solitary night rounds at the barracks (Donner, Levonian, & Slutsky, 2005; McEwen & Wills, 2011). After her return to Great Britain Nightingale continued to advocate for the improvement of care and conditions in Britain’s military and civilian hospitals and lead many campaigns promoting hospital reforms.

Among Florence Nightingale achievements is the creation of the first official nursing training program, the Nightingale School for Nurses, opened in 1860. Florence Nightingale’s trained nurses spread high standards of nursing care to other hospitals by training other nurses.
(Nightingale & McDonald, 2009). The procession of the Lamp, a ritual perpetuated yearly during the commemoration held at Westminster Abbey on May 12 (Nurses Day and Nightingale’s birthday), symbolises Nightingale’s vision and legacy to pass on the knowledge of nursing (Bakewell, 2011).

Compared to Florence Nightingale for the extent of her work both nationally and internationally, Virginia Henderson, pillar of modern nursing, was granted the title of "Foremost Nurse of the 20th Century" (ANA, 2012). Virginia Henderson’s Principles and Practice of Nursing, definition of nursing and theory of needs widely influenced the practice of nursing taught in nursing schools (ANA, 2012; Watkins, 1996). Henderson was truly committed to clarifying the nursing roles and finding ways to better prepare nurses to assume these roles (Henderson, 2006). Accomplished writer and nurse educator, Henderson was acknowledged for her research on nursing education particularly her revision of Hamer’s classic textbook of nursing and her participation with others to the development of a basic nursing curriculum for the NLN (McEwen & Wills, 2011; Watkins, 1996).

Then, health education is a current national matter. The National Prevention Strategy (NPS), America's Plan for
Better Health and Wellness, was released in June 2011, by the National Prevention Council. The NPS vision is “Working together to improve the health and quality of life for individuals, families and communities by moving the nation from a focus on sickness and disease to one based on prevention and wellness” (p. 7). The NPS proposes a set of comprehensive strategic directions and priorities (Appendix B) among which “Empowered People” that promote health education as a mean to provide individuals and families with the necessary tools for healthy lifestyles choices.

The Centers for Disease Control and Prevention (2011) pointed out many Americans suffer and die (seven out of 10) from preventable chronic diseases. Nevertheless, research has shown that nine out of 10 adults find it difficult to understand and use the health information available to them to make lifestyle changes (Rothman et al., 2006; Kutner et al., 2006).

Public Health in America statement is another important national reference that promotes a similar message. In July 1995, the Public Health Functions Steering Committee members released a statement (adopted in the Fall 1994) that outlined a vision, a mission, purposes and essential public services for public health in America.
Besides the strong mission—Promote Physical and Mental Health and Prevent Disease, Injury and Disability— one of the essential public health services is to inform, educate, and empower people about health issues (see Appendix C).

Statement of the Problem

As previously discussed nurses are more likely to be involved in patient/client education and to educate clients in groups whatever setting they work in and are expected to do so (Bastable, 2008) although they are not always prepared for this role (Rowlands, 1987). The process associated with teaching is defined by Bastable (2008) as "a systematic, sequential, logical, scientifically based, planned course of action consisting of two major interdependent operations, teaching and learning" (p. 11). It is a complex activity: Ball and Forzani (2010) even labeled it unnatural because it requires that one breaks into pieces a knowledge and makes it understandable and learnable by others with different learning needs than its own. A few nursing programs have started to address this concern (McKenna & French, 2011; Tai & Chung, 2008).

The California State University San Bernardino (CSUSB) includes a campus located in Palm Desert (PDC). Two nursing
programs are offered: Bachelor of Science Nursing (BSN) and Registered Nursing (RN) to BSN. Several courses include assignments that consist of giving a presentation to patients. The BSN psychiatric course coordinator voiced some concerns regarding the ability of students to complete such an assignment when most of them had not yet received individual teaching instructions. Besides, other faculty members had the same concerns as several courses’ clinical component include a teaching assignment. This coincided with the investigator’s reflection about nurses’ basic education about patient education in group setting. The investigator discussed with the faculty members the possibility of including to the courses a preparation to patient education in group setting in the form of a workshop. Immediate concerns emerged from this idea: (1) How would students respond to the opportunity of attending this workshop? (2) Would the workshop fit across disciplines in the current curriculum? (3) Would the students be able to perform group teaching in various settings?
Purpose of the Study

The main purpose of the study was to describe the impact of a group teaching preparation on Baccalaureate nursing students’ perception of their group teaching knowledge, level of preparation and level of comfort. Additionally the investigator was interested in finding out (1) if the students really had an interest in learning how to better teach, (2) if the faculty had an interest in adding such a preparation to their current undergraduate nursing curricula; (3) what it would take to implement such a preparation on a regular basis throughout the programs.

Besides, the investigator wanted to provide students with an effective preparation to help them feel better prepared to do their group teaching assignment, present teaching strategies to be successful even in unexpected situations and evaluate the efficacy of the overall preparation (workshop).

Hypothesis

Basic group teaching education will improve baccalaureate nursing students’ perceived knowledge, level of preparation and level of comfort regarding group teaching.
Definition of Terms

- Group teaching, also referred as patient education in group setting relates to education provided to a group of clients/patients. This differs from a support group or a therapeutic group.

- Group teaching population: diversity of clients/patients from different cultural background and multiple issues. These clients/patients are often vulnerable, low-income, sick and/or mentally challenged. Their motivation to learn and/or their educational background are likely to be unknown at the time of the teaching presentation.

- Perceived knowledge: Students’ self-assessment of their knowledge about patient education in group settings.

- Perceived level of preparation: Students’ self-perception of their level of preparation to teach a group of clients before and after the workshop.

- Perceived level of comfort: Students’ perception of how comfortable they felt while implementing their assignment and underlying self-confidence.
CHAPTER TWO
REVIEW OF THE LITERATURE

The review of the literature will address the relevant issues about the teaching role of nurses in practice. The rational for the need of nurse educators; the nurse educator role and perceptions; the knowledge and skills required to teach and the specificity of teaching in a group setting will be first be discussed. Then the debate about educational preparation of nurses as patient educator will follow and examples of nursing programs that have incorporated principles of teaching and learning courses in their undergraduate nursing curricula will be presented.

Nurse Educators: A Need in the Current Socio-economic Context

There is an active debate about the need of nurse educators in the healthcare system. Bastable (2008) pointed out the paradigm shift in patient education practices from a focus on disease to a health promotion one. The current healthcare crisis is part of the equation as the number of Americans who cannot afford health insurance is on the rise and the cost of healthcare dear:
About fifty millions adults 18-64 years old (25 %) indicated that they were uninsured in the first quarter of the year 2010, for at least part of the past 12 months. This represents an average increase of 1.1 million compared to the previous year. This situation does not affect only those living in poverty as thirty two percent of middle-income households adults 18-64 year reported being uninsured for at least part of the past 12 months (CDC, 2010).

The National Health Expenditure (NHE) was estimated at $2.5 trillion in 2009, which represented $8,086 per person and 17.6% of the Gross Domestic Product. Medicaid spending was $373.9 billion in 2009, a 9.0% increase or 15% of the total NHE. Out-of-pocket spending was $299.3 billion in 2009, which accounted for 12% of the total NHE. Finally, California's aggregate personal healthcare spending reached 10.8% of total U.S. personal healthcare spending in 2004—the highest in the nation (Centers for Medicare & Medicaid Services, 2011).

The national prevention guidelines (NPS, 2011) and Healthy People 2020 (http://www.healthypeople.gov/2020/default.aspx), portray the healthcare practices shift to a preventive approach
indicating the unavoidable need for patient education discussed in Close (1988), Hills and Lindsey (1994) and Davies (2006). While the CDC (2011) identifies chronic disease as a factor of death, Redman (2011) has claimed that incomplete education in settings such as hospital and emergency rooms discharges may imperil patients especially individuals affected by chronic diseases, who need to learn disease self-management and adopt a healthier lifestyle. Previously the World Health Organization (WHO) had recognized that lifestyles and environmental factors were responsible for major health problems (Nikolai, 1995).

Definition and Roles of the Nurse Educator

Teaching as an essential component of nursing practice is well established (Bastable, 2008; Carpenter & Bell, 2002; Close, 1988; Delaney, 1994; Lamiani & Furey, 2009; Milde & Heim, 1991; Naik, Teal, Rodriguez, & Haidet, 2011). Health teaching is cited as a component of nursing practice as early as the 1976 Nurse Practice Act recommended by the The American Nurses Association (Bartlett, 1986). Multiple facets of the teaching role in nursing practice are found in the literature.
First, the expression nurse educator is often associated with the academic nursing role (Cahtro, 2011; Gibson, 2011; Kalb, 2008; Kowalski, Horner, & Houser, 2011; NLN, 2012). In The Scope of Practice for Academic Nurse Educators, the NLN’s Certification Governance Committee defines nursing education as “the facilitation of learning through curriculum design, teaching, evaluation, advisement, and other activities undertaken by faculty in schools of nursing” (NLN, 2005, p. 2). This document set the standards for academic nursing education, acknowledging it as “a specialty area and an advanced nursing practice role” (p. 1).

Additionally, authors discussing the nurse educator role have often addressed the current national concern about the deepening shortage of the nursing faculty as well as the challenge to attract doctoral students (Baker, Fitzpatrick, & Griffin, 2011; Cahtro, 2011; Ellenbecker, 2010; NLN, 2010; Penn, Wilson, & Rosseter 2008). Identified factors associated with the faculty shortage include mandatory doctoral preparation for nurse educators; cost of education and wages; necessity to work while attending graduate school; decrease in available doctoral programs and geographical access to these programs (Baker,
Kowalski, Horner and Houser (2011) explained that this shortage also applied to clinical instructors in the state of Colorado. The shortage of clinical instructors’ was found three times greater than the faculty shortage (Colorado Center for Nursing Excellence, 2004). To address this issue, the Colorado Center for Nursing Excellence developed a 40-hour workshop to prepare clinical expert nurses, conceptualized as Clinical Scholars, to teach nursing students during their clinical rotations. The clinical scholars, nursing students and clinical scholars' agencies surveyed about the project, all expressed their satisfaction. The intervention was successful in increasing and retaining clinical scholars. Importantly, clinical scholars indicated an increase in job satisfaction and the investigators observed an improved patient safety (Kowalski et al., 2011).

Secondly, the role of nurses in patient education is discussed. The importance of the patient educator role in nursing is acknowledged by many authors (Barrass, 1992; Bastable, 2008; Clarke, 1991; De Young, 2009; Lamiani & Furey, 2009). Mooney, Timmins, Byrne and Corroon (2011)
agreed with the findings of Polh (1965) regarding nurses’ uncertainty about their role in patient education.

There is debate in the literature about the definition of the nurse’s role in patient education; the place of nurses in the field of health education/health promotion and the implementation of this role in all healthcare settings. Syred (1981) and Tilley, Gregor and Thiessen (1987) suggested that nurses should elaborate a clear definition of this role focusing on patient education efficacy. Published by the American Journal of Health Promotion in 1986 and proposed by O’Donnell the definition of health promotion: “the science and art of helping people change their lifestyle to move toward a state of optimal health” was well received. Following national trends, the same author developed a more comprehensive definition in 2009. Tilley et al. (1987) argued that there is a misinterpretation of nursing’s inadequacy in the field of health promotion that he attributed to the many definitions and uses of the term “health promotion” in academia and practice.

Clarke (1991) emphasized that building empathetic relationships with patients could play an important role in helping them making healthier choices.
educational interventions can be considered a support to patients’ lifestyle changes (Tilley et al., 1987).

Rowland, 1987 argued that nurses participation in health promotion should start by role modeling despite the difficulty and stress associated with it. He indicated for instance, how unlikely it would be for a health educator who smokes and is overweight to be credible in his counseling a patient about the harmful effects of smoking and obesity. Clarke (1991) disagreed and claimed that the public still value the health information provided by such a nurse. The author claimed that the necessary skills to be a nurse health educator are more related to “internal mechanisms”.

Finally the role of the nurse educator, whether faculty, clinical instructor or patient educator, as defined by Bastable (2008) “is not primarily to teach, but to promote learning and provide for an environment conducive to learning” (p.13). This challenge can be accomplished with curriculum design, teaching methods, evaluation and advisement focusing on learners’ needs (NLN, 2005).
Perceptions and Responsibility

Many studies are related to nurses' teaching role perception and related responsibility (Barrett, Doyle, Driscoll, Flaherty, & Dombrowski, 1990; Kruger, 1991; Little, 2006; Milde & Heim, 1991; Trocino, Byers & Peach, 1997).

Among nursing professionals, there is definite agreement about the teaching component of the nursing role and its importance. Nevertheless, research has shown paradoxical answers to surveys examining nurses' beliefs and perceptions about their health educator role and the extent of the value they attached to this function.

In a study from Kruger (1991) where staff nurses, nurse administrators and nurse educators were asked to share their opinion about nurse responsibility in patient education using a five-point Likert scale questionnaire, all nurses rated this responsibility as high although the staff nurses rated it much lower than others. Yet all nurses rated their responsibility in achievement of patient education below three (good) on a scale of one to five.

Similarly, 465 nurses from an acute care hospital, surveyed about their role of patient education evaluated it as satisfying. However, staff nurses who spend more time
with patients than other nurses felt the least prepared to teach patients. Most of the participants were baccalaureate prepared but the sample also included clinical nurse specialists (mastered prepared). These nurses did not perceive themselves as having a great role in patient education as staff nurses did. They considered themselves educators more for nurses than for patients (Barrett, Doyle, Driscoll, Flaherty & Dombrowski, 1990).

Trocino, Byers and Peach (1997) reported comparable findings and additionally the authors suggested that the extent of nurses’ beliefs and attitudes towards patient and family education was associated with their level of licensure.

Studies regarding nurses’ perception of teaching performance have also been implemented in the nursing school setting. Milde and Heim (1991) surveyed two baccalaureate nursing programs’ students (n = 99) and faculty (n = 25) about their perception of the required competence to provide health education. A 41-item questionnaire was used to determine present and desired competence. The results revealed that students rated their current level of competence at a higher level than the faculty expected them to attain at the end of the program.
The authors described the "competent" level as the ability to provide efficient health education without supervision. Both faculty and students rated their current competence lower than the desired competence and felt less skilled in teaching a group of clients.

A similar conclusion was found by second-year nursing students studied by Little (2006). Like the authors of this previous study, Little believes that the challenge of teaching students the theory and skills to become nurse educators should be addressed in nursing school curricula. An evaluation was done using a Likert-scale questionnaire to examine students' perceptions of the workshop. They rated the video-taped, teaching-learning workshop as "definitely valuable". Moreover, faculty members indicated that students who participated in the workshop demonstrated a significant level of confidence when teaching clients. That is very similar to the findings presented in the group teaching study where 94% of study participants felt comfortable performing their teaching assignment after attending the workshop.
Group Teaching

The history of teaching can be traced to the early 1800s with Florence Nightingale’s work and advocacy of the sick and the poor and public health at a large. She made a difference between “sick nursing” and “health nursing” and emphasized the need for nurses to teach proper hygiene and sanitation to individuals (Monteiro, 1985). She viewed “pure air, pure water, efficient drainage, cleanliness and light” as essential factors in maintaining health (Nightingale, 1860, 1957, 1969, p.24). She advocated for district nursing in her 1894 paper Health Teaching in Towns and Villages (Monteiro, 1985). In the United States, the development of patient education and particularly group teaching was associated with the necessity of preventing the spread of tuberculosis, the principal cause of death at the time (Bartlett, 1986). In an effort to better care for the growing military veteran population severely affected by the disease, the Veteran Administration (VA) hospitals developed the first organized patient education program in 1949, at the Denver General Hospital. This model was replicated in 18 other VA hospitals (Bartlett, 1986). The U. S. Public Health Services (USPHS) collaborated in the implementation of these health education programs. The
Society for the Prevention of Tuberculosis, the first organization in the world addressing tuberculosis prevention, was founded in 1894, and provided educational measures as main preventive strategies (Bartlett, 1986). Later the need for diabetic education led to the development of more organized patient education programs and to the establishment of a committee on patient education at Boston City Hospital in 1955 (Bartlett, 1986).

However, not much is found in the literature regarding patient education in a group setting (group teaching) or group teaching evaluation. Articles on the usefulness of support groups and small group dynamics are found; for instance, the efficacy of psychoeducational support group for breast cancer high genetic risks exposed women (Karp, Brown, Sullivan & Massie, 1999). Examples of themes developed in these group sessions include, emotional impact of family members' death, overestimation of anxiety and body self-image. The goal of this intervention was to provide emotional support to assist the patients in making a choice regarding prophylactic mastectomy. Similarly, McCullough & Simon (2011) discussed the positive impact of a peer support group for the siblings of children with developmental disabilities. The intervention aimed to
provide an opportunity for siblings to express their feelings about their sibling disability in a safe environment.

The only document dedicated to group teaching found was a 1961 publication of the World Health Organization, "Aspects of Public Health". One chapter addressed group teaching in Public Health Nursing. This document describes several studies related to public health nurses (PHN) from different health departments' reporting not feeling prepared or ready to lead and teach groups (Murphy, 1961).

In public health or community health nursing research, group teaching is rather presented as an intervention. Most studies relate to disease or topic outcomes but rarely the teaching quality, efficacy of the teaching methods and how the content is taught are discussed. The teaching evaluation focuses on behavioral change and/or health outcomes improvement (Davies, 2006) following current national trends. Two studies illustrate this statement:

First, Sultemeier (1988) described an experiment with pregnant women who were identified as non-compliant with prenatal nutrition individual teaching. The clinical consequences included anemia, inappropriate weight gain and inadequate dietary intake. Group teaching was used to
present prenatal nutrition information. A positive change in dietary intake was observed in 50% of the pregnant women who attended the group teaching sessions. Moreover, less staff and time were spent for group teaching. In this study, the overall focus was on group teaching and individual teaching as a method of intervention. No reference was made on how the teaching was done whether in individualized sessions or in groups. The characteristics of the study population such as age, parity, cultural background and income category were not discussed. Such factors could significantly influence the interpretation of the results presented (Bastable, 2008; DeYoung, 2009).

In previous years, McNeil and Holland (1972) had already demonstrated that teaching to groups was more cost-effective than home visits. It is important to mention that the authors did not state that group teaching was more effective than home visits but specified that group teaching was more cost-effective than home visits. Differences in teaching competency of nurses were recognized as variously affecting mothers’ learning although, teaching ability was not examined. Nurses in this study had at least a BSN and public health educational background.
Teaching and Learning Process

Before discussing the teaching instructions in undergraduate curriculum, it might be useful to look at what teaching entails. Many authors are convinced of the complexity of the task of teaching and the specific set of skills required to perform health education well (Barrass, 1992; Bastable, 2008; Clarke, 1991; DeYoung, 2009; Little, 2006; Loewenberg Ball & Forzani, 2009; McKenna & French, 2011). If Loewenberg Ball & Forzani (2009, 2010) characterize teaching as unnatural, Little (2006); Mooney et al. (2011) and Ellenbecker (2010) argued that appropriate training is necessary to obtain efficient teaching. Loewenberg Ball & Forzani (2009) noted that "teaching, defined as helping others learn to do particular things" was done daily and could be done by anyone contrary to professional classroom teaching (p. 498). These authors claimed that professional classroom teaching is a specialized function that differs significantly from informal teaching. They characterized the act of teaching as unnatural because of the level of expertise needed to be able to understand a learner’s need and provide customized learnable contents to satisfy these needs. The same authors pointed out that knowledge about Child development does not
guarantee the ability of a school teacher to understand children’s ideas and teach in a fair way (Ball & Forzani, 2010). Close (1988) made the same statement regarding nurses, indicating that a great knowledge of the subject matter does not mean patient education competency. DeYoung (2009) stated that effective education requires the nurse educator to be knowledgeable not only about the subject matter but also about the teaching-learning process. Close (1988) had previously discussed the similarity between the teaching learning process and the nursing process. The author had classified patient education as a nursing intervention that should follow the steps of assessment, planning, implementation and evaluation. In Close’s opinion, the practical implementation of patient education should be considered and evaluated as a basic component of nursing care and a requirement for all nurses. Likewise, Little (2006) suggested that students should learn how to integrate the principles of teaching and learning in complex health education situations.

As specified by DeYoung (2009) and Little (2006) teaching/effective educational intervention encompasses more than the giving of information. Basic assessment skills should allow the nurse to evaluate
patients/students’ readiness to learn, motivation and ability to learn (Noble, 1991).

Teaching individuals is different from teaching groups as the teacher/educator has to take in consideration all students’ perspectives that may be different from his/her own (Lowenberg Ball & Forzani, 2010). Felder (1996) recommended using all learning styles when lecturing so that students’ preferred style is offered as least part of the time what Felder referred to as “teaching around the cycle”. This author also pointed out that using teaching methods in a style less favored by the student in addition can help him or her build new skills.

Another challenge facing the nurse educator is to present the content to be learnt in a culturally sensitive way without stereotyping. For instance, classifying the ethnic groups in the same category may lead to negative affects and loss of individuality (DeYoung, 2009). Moreover, the greater the cultural, language and experience differences between teacher and learner the harder it is to meet students’ personal and specific needs (Lowenberg Ball & Forzani, 2010).

Successful group teaching implies knowledge in learning, motivation and behavior change theories (DeYoung
expertise in the domains of learning and teaching methods (Bastable, 2008). Behavior change models such as the Health Belief Model and Prochaska and DiClemente Stages of change have also been cited by authors as key elements to teach effectively (Bastable, 2008; DeYoung 2009). Besides, the educator interpersonal skills, self-confidence and relationship-building with the client/patient may affect teaching efficacy (DeYoung, 2009).

Models of adult learning such as Knowles (1984) have been used in the nursing practice. Knowles (1984) invited the educator to simply focus on helping adults to learn. In order to do so, the educator has to understand how an adult learns and must take into consideration his or her existing knowledge and readiness to learn (Barrass, 1992).

Syred (1981) acknowledged the Health Belief Model (HBM) as an efficient framework in preparing nurse-led health teaching. He suggested to incorporate the HBM in the nursing care plan making teaching activities part of the patients daily care. In addition to other theoretical knowledge and skills required and regardless of the teaching methods used, engaging the patient and encouraging him to participate as much as possible has been evaluated
as a key element in facilitating effective learning (Webber, 1990).

Despite its complexity, Lowenberg Ball & Forzani (2010) consider that the practice of effective teaching is learnable. Although educators must adjust their way of teaching to learners' different styles, teaching is not totally unpredictable. There is common knowledge about learners, classrooms, and subject matters that can be learnt. Milde and Heim (1991) suggested that the expected skills level for proper teaching should be discussed with students so that they have reasonable expectations for their performance.

Patient Teaching Component in Baccalaureate Nursing Program

Although RNs are expected to be competent to teach individuals, groups and communities (Bastable, 2008; Little, 2006), patient and family education provided by nurses has not been effective (Trocino, Byers & Peach, 1997; Close, 1988). Some authors discuss the lack of formal training (Donner, Levonian, & Slutsky, 2005; Halcomb, 2010; McKenna, 1996). Others simply emphasize the need for formal preparation (DeYoung, 2009). Hills and Lindsey (1994),
Ellenbecker (2010) and Halcomb (2010) agreed asserting that nursing education must be diametrically reshaped and shifted to embrace a health promotion approach and meet society’s health needs. Ellenbecker (2010) maintained that the multiple educational paths to nursing practice contribute in limiting the evolution of nursing education. Additionally it maintains today’s situation of nursing shortage and workforce unpreparedness to answer current and future societal needs. The author claimed that standardizing the baccalaureate nursing degree as the initial requirement for entry into nursing practice would prepare nurses earlier to assume the roles of educator, researcher and advanced practice nurse.

There is also a debate in the literature about the educational preparation of nurses as patient educator.

This group teaching study is about providing teaching instruction to undergraduate nursing students to improve their teaching experience. Currently, most undergraduate nursing curricula do not include specific courses addressing how to perform group teaching. The PDC BSN and RN to BSN current curricula do not include a course introducing the principles of teaching and learning (http://pdc.csusb.edu/majorsPrograms/RNtoBSN.html ;
http://pdc.csusb.edu/majorsPrograms/RN.html) although both individual and group patient education are required clinical activities in several courses.

Even the Essentials of Baccalaureate Nursing Education for Entry-Level Community/Public Health Nursing reviewed and published by the Education Committee of the Association of Community Health Nursing Educators does not clearly single out a teaching competency. It is simply specified in the document that a BSN PHN should be prepared to “educate individuals, families, communities, and populations about health issues” (2009, p. 10). However, there is evidence that a multiple-level effort is taking place to address this issue. Innovative initiatives from nursing programs have been published.

In 2006, the Massachusetts Department of Higher Education (DHE) and the Massachusetts Organization of Nurse Executives developed a nursing initiative called “Building the Framework for the Future of Nursing Education and Practice”. They convened thirty-two experienced professionals from major statewide stakeholders in nursing education and practice. One of their identified priorities was the “development of sufficient consensus on competencies to serve as a framework for educational
curriculum" (p. 3). The outcome of the meetings was the “Nurse of the Future Nursing Core Competencies”, an Evidenced-based Core Competency Model. The communication module includes a teaching/learning component (DHE, 2010, p. 30).

Following the recommendations of the Pew Health Professions to match the need of changing healthcare system, from acute hospital setting to community setting (Donaho, Mudge & Price 1997; Speck, 2003), a nursing school from Louisville, Kentucky decided to place an aggregate community health nursing course in the first semester of the undergraduate program instead of the last year as it traditionally was. Part of the course included planning and implementing health education presentations in public school classes. An evaluation of the presentation was also completed at the end. This change provided an opportunity for students to learn and experiment research and what it entails. However, changes also led to challenges: students lacked medical/surgical knowledge, students primarily interested in the hospital setting were hesitant to enroll and there was a lack of community/health faculty (Speck, 2003).
Little (2006) emphasized that nursing students should be offered the opportunity to acquire the basic teaching skills and self-confidence necessary to teach effectively in a non-threatening learning environment. The author described the example of the Selkirk College Collaborative nursing program curriculum that includes an overview of learning theories and an introduction to principles and processes of teaching and learning in the Professional Growth course during the second year of the program. These notions are introduced in the second year to give students enough time to experience the diversity and complexity of patient education. Two main concepts are reinforced in the course: (1) teaching is more than just the giving of information and (2) one cannot assume that what was taught is systematically learnt.

McKenna and French (2010) pondered (1) nurses' responsibility to share knowledge with others and (2) the feeling of unpreparedness that causes nurses to be reluctant to teach. Hence, they decided to focus on peer teaching. They designed a semester-long core unit for final (third)-year students to increase their knowledge and skills to facilitate teaching and learning in practice. Then these third-year students taught the first-year
students. Both group of students completed an evidenced-based evaluation questionnaire. The outcome was increased confidence in knowledge and teaching ability for the third-year students. Additionally, these students indicated that the experience was rewarding as it helped them reflect on their own learning. The first-year students felt comfortable learning skills from senior peers. Both groups acknowledged teaching as part of the nursing role.

Summary

Although nurses are expected to be health educators (Bastable 2008; Little 2006) and are in a unique position to take the lead in this role they do not always embrace it (Rowlands, 1987; Syred, 1981). Nonetheless, nurses will be involved in some type of patient education or student mentoring wherever they work regardless of their teaching skills and opinion on this matter (Close, 1988).

National health statistics revealed that the number of Americans suffering from chronic disease and without health insurance is growing (CDC, 2010, 2011). The NPS and Healthy People 2020 recommend health promotions strategies aiming to empower people and provide them with the appropriate knowledge to make healthier lifestyle choices.
Health education has been acknowledged as an essential component of the nursing practice since the nineteen century. The different aspects of the nurse educator role (faculty, clinical educator and patient educator) are described in the literature. There is a strong agreement on the importance of the teaching role of nurses and the associated responsibility among researchers and nurses themselves. However the extent of the value nurses attach to their health educator role is not clear. They may accept responsibility for patient education then deny responsibility for achievement of patient education (Kruger, 1991); or they may indicate being satisfied with their patient education role and later claim not feeling prepared to teach efficiently (Barrett et al., 1990). This may be related to a lack of clear definition of “health promotion” and “health education” terms, evoked by Tilley et al. (1987). Nonetheless, the work of pioneers such as Florence Nightingale, the ANA and the NLN has influenced and clarified the standards for the nurse educator.

Patient education in a group setting or (group teaching) and/or group teaching evaluation is not often referenced in the literature. Studies primarily focused on
patient outcomes and intervention evaluation. Not much is said about the "how to teach".

Teaching is a specialty and requires expertise, knowledge and practice in teaching and learning principles. It is learnable (Lowenberg Ball & Forzani, 2010).

There is a debate in the literature about educational preparation of nurses as patient educator. Creative models that include principles of teaching and learning courses in undergraduate nursing curricula have been piloted. Although encouraging these examples bring up the challenges associated with such models.

There is need for further research in this practice area (Bastable, 2008). Engelmann (2011) suggested that teaching knowledge should be combined with research to generate evidenced-based teaching practices.
CHAPTER THREE

METHODOLOGY

The study describes the impact of preparation on the participants' group teaching perceived knowledge, perceived level of preparation and perceived level of comfort. It particularly examines the efficacy of a group teaching workshop on Baccalaureate nursing students during their Community/Public Health Nursing, Intermediate Nursing Process, Roles and Skills or Psychiatric clinical class rotation.

Study Design

This is a descriptive pilot study. The intent of the study is to "describe relationships among variables rather than to infer cause-and-effect relationships" hence it is a descriptive correlational study, as defined by Polit and Tatano-Beck (2008, p.275). No inferences or statistical analysis were made.

Study Sample

Participants included CSUSB PDC baccalaureate nursing students in Public Health, Intermediate Nursing Process,
Roles and Skills or Psychiatry clinical class rotations, which all require a group teaching assignment. N405 RN to BSN students are Registered Nurses (RNs) licensed by the California State Board of Nursing who are preparing their Bachelor Science in Nursing (BSN). They are enrolled in the Community/Public Health Nursing course. N401 and N220 BSN students are individuals who are not yet RNs but who are also studying for their BSN. They are enrolled in the Psychiatric course and Intermediate Nursing Process, Roles and Skills course.

Methods

As previously stated, the study focuses on the impact of preparation on the participants’ group teaching knowledge. The preparation consisted in a workshop discussing basic group teaching skills and teaching strategies to be successful even in unexpected situations. A copy of the workshop agenda and PowerPoint are available in Appendices D and E. The importance of teaching as part of the nursing role was covered in the introduction as well as relevant nursing theories. The California Nursing Act and other important public health documents were also discussed and the levels of prevention reviewed.
Additionally, interactive activities were included to introduce students to learning theories, concepts of learning and what it involves (see Appendix E, p. 99). The role-play scenarios (Appendix F) and "Tips for Group Teaching Successful Management of Unexpected Situations" handout (Appendix G) presented during the last part of the workshop, provided an opportunity for students to reflect on and experience unexpected situations when performing group teaching.

Study Timeline

Time 1

The study was introduced to students the day of the workshop. Students received a short presentation that described the study, the details of their participation and possible benefits they could receive. The investigator described the study and answered any questions the potential student participants had. The investigator distributed the Group Teaching Study Consent Form (Appendix H) and the Group Teaching Study Participant Information form (PIF). The Consent Form included a clause to deny participation. All students returned their signed or declined Consent Form along with their completed or blank
PIF in a sealed envelope that the investigator retrieved. Students were instructed not to disclose their decision regarding participation to their instructor to maintain confidentiality. In addition, to prevent student coercion, the investigator did not provide the instructors with any information regarding student participation status.

The PIF (Appendix I) was intended to collect information about participant characteristics, previous experience regarding group teaching as well as perceived level of preparation before attending the workshop.

The workshop was given to the students as a whole, both participants and non-participants alike. All students completed the Group Teaching Pre-test (Appendix J) at the beginning of the workshop and the Group Teaching Post-test (same questions, see Appendix J) at the end of the workshop. All students returned their completed pre- and post-tests. However, only the data of the students who elected to participate in the study were used. All students received a folder with educational resources the day of the workshop. Dinner or lunch, snacks and drinks were also offered.
Time 2

After the workshop, the students had four weeks to apply the strategies learnt and complete their group teaching assignment. All students completed this assignment—regular clinical requirement for the course.

Time 3

Time 3 consisted of surveys' completion. All students were invited to complete the Group Teaching Post Assignment Survey (PAS) but only the data of the students who elected to participate in the study were used (see Appendix K). Study participants were asked to complete an additional survey, the Group Teaching Exit Survey (ES) (Appendix L). These questionnaires were provided electronically (Survey Monkey format). The instructors made the PAS Survey Monkey link available to all students on the school server (Blackboard). Study participants received both PAS and ES links from the investigator via email. The feedback on the completed assignment provided an opportunity to evaluate the efficacy of the workshop (PAS) and information on effective strategies used and/or specific difficulties encountered by the students during the group teaching assignment (ES). Study participants received clinical hours for their participation in the study activities.
The Group Teaching Study Timeline (Appendix M) summarizes the different phases of the study.

Data Analysis Procedures

First, the data collected in this study consist of participants' self-report of their experience. The investigator did not directly observe the students performing their group teaching assignments and did not discuss any aspect of the efficacy of their intervention with the instructors. Another important element to take into consideration is that many questions of the PAS and ES are open-ended. Consequently, a large portion of the data collected is more qualitative than quantitative despite the original quantitative design of the study.

The data were analyzed as follow:

a) Participant characteristics: Percentages were calculated for participants' gender, year of study, previous and current group teaching experience. The sample mean was calculated for participants' age. This data were collected with the PIF (Appendix I).

b) Participants' perceived group teaching knowledge: The Group Teaching Pre-test and Post-test were used to examine the participants' perceived knowledge the day of
the workshop. The Group Teaching Pre-test and Post-test (Appendix J) consisted of the same set of 12 questions. The first four questions related to general teaching knowledge. The questions that followed addressed unexpected situations. The Pre-test was taken just before the workshop and the Post-test, at the end of the workshop. The percentage of participants with the highest scores was calculated as well as the median for both tests after which the percent change was calculated.

c) Participants’ perceived level of preparation: The data regarding the perceived level of preparation were obtained twice using a four-point Likert scale (Great Extent, Somewhat, Very little, Not at all): (1) before the workshop (Time 1) from the PIF question: “To what extent do you feel prepared to teach in a group setting?” and (2) after the workshop (Time 3) from the PAS question: “To what extent did you feel prepared for your group teaching assignment?” Percentages were calculated for each category and results were compared before and after the workshop as well as the percent change. Answers were reorganized to answer the question: Do participants feel prepared to do their group teaching assignment?
d) Participants’ perceived level of comfort: The data regarding the perceived level of comfort were also obtained with a four-point Likert scale (Great Extent, Somewhat, Very little, Not at all) from the PAS question: “To what extent did you feel comfortable in implementing your group teaching assignment?” Percentages were calculated for each category. Results were re-organized to answer the question: Did participants feel comfortable implementing their group teaching assignment?

e) Workshop evaluation highlights: The ES (Appendix L) gave participants an opportunity to provide qualitative feedback on the workshop they attended. This section will provide highlights of the students’ answers. Seventeen students completed the ES (BSN students n = 13; RN to BSN n = 4).

f) Unexpected situations: The last part of the workshop focused on unexpected situations encountered while implementing group teaching. Study participants had an opportunity to share their experience of unexpected situations in the PAS and ES. This section of the results will first provide information about the participants’ assignments, then briefly describe what the students reported.
CHAPTER FOUR
RESULTS AND DISCUSSION

Results

Thirty-one students attended one of the three workshops conducted in the laboratory of the Palm Desert Campus. Sixty-four percent \((n = 20)\) agreed to participate in the study and completed the PIF, the pre-test and the post-test. However, one student did not turn in the pre-test.

Eighty percent \((n = 16)\) completed the PAS and 85% \((n = 17)\) completed the ES.

a) Participant Characteristics:

Participants included CSUSB PDC baccalaureate nursing students. As shown in Figure 1 most participants were enrolled in the BSN entry-level program and were in the second year of the program. The majority was female (75%). The mean age was 30 although the RN to BSN students were much older (mean age 42). Sixty-five percent of the students reported that they had a previous group teaching experience (see Table 1). Most RN to BSN students had previous group teaching experience (60%) compared to BSN students (20%).
Figure 1. Participants' Program Attended and Year of Study
Table 1

Participants’ Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total Sample (n = 20)</th>
<th>BSN Students (n = 15)</th>
<th>RN-BSN Students (n = 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Mean = 30</td>
<td>Mean = 27</td>
<td>Mean = 42</td>
</tr>
<tr>
<td></td>
<td>Range = 21-52</td>
<td>Range = 21-40</td>
<td>Range = 30-52</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>75% (n = 15)</td>
<td>73% (n = 11)</td>
<td>80% (n = 4)</td>
</tr>
<tr>
<td>Male</td>
<td>25% (n = 5)</td>
<td>27% (n = 4)</td>
<td>20% (n = 1)</td>
</tr>
<tr>
<td><strong>Year of Study</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First</td>
<td>20% (n = 4)</td>
<td>27% (n = 4)</td>
<td>0% (n = 0)</td>
</tr>
<tr>
<td>Second</td>
<td>65% (n = 13)</td>
<td>67% (n = 10)</td>
<td>60% (n = 3)</td>
</tr>
<tr>
<td>Third</td>
<td>15% (n = 3)</td>
<td>6% (n = 1)</td>
<td>40% (n = 2)</td>
</tr>
<tr>
<td><strong>Previous Group Teaching</strong></td>
<td>Yes = 65% (n = 13)</td>
<td>Yes = 67% (n = 10)</td>
<td>Yes = 60% (n = 3)</td>
</tr>
<tr>
<td><strong>Current Group Teaching</strong></td>
<td>Yes = 30% (n = 6)</td>
<td>Yes = 20% (n = 3)</td>
<td>Yes = 60% (n = 3)</td>
</tr>
</tbody>
</table>

b) Participants’ Perceived Group Teaching Knowledge:

Figures 2 and 3 show the percentage of participants with correct answers. Although the total sample included 20 participants, one RN to BSN student did not submit the pre-test so this student’s data were excluded for both the Pre-test and Post-test for a final n of 19.
Figure 2. Group Teaching Pre-test Results

Note: x-axis represents the number of correct answers. 12 is the maximum. Participants completed the Pre-test before the workshop.

As shown in Figure 2, the Group Teaching Pre-test scores ranged from 9 to 12. Of the total sample (n = 19), almost half of the students (47% n = 9) scored 83% or 10 correct answers out of 12, and the median. Most BSN students scored 9 whereas 75% of the RN to BSN participants scored 11. Only one of the participants, a BSN, scored 12.
Figure 3. Group Teaching Post-test Results
Note: x-axis represents the number of correct answers. 12 is the maximum. Participants completed the Post-test after the workshop.

As displayed in Figure 3, the test scores improved with a range of 9 to 12 correct answers, compared to 8 to 12 correct answers on the pre-test. No students scored below 75%. Among the total sample, 47% (n = 9) of the students answered all questions correctly (score of 12) compared to only 5% on the pre-test. This represented 42%
percent increase. The median went from 10 to 11 correct answers out of 12. Fewer students (21%), all in the BSN category, scored 9. No RN to BSN student remained in the 9 or 10 range of correct answers.

c) **Participants' Perceived Level of Preparation**

Figures 4 and 5 portray the participants' self-assessment of their level of preparation to conduct group teaching.

---

**Figure 4. Participants’ Perceived Level of Preparation Before the Workshop**

<table>
<thead>
<tr>
<th>Level of Preparation</th>
<th>Total Sample (n = 20)</th>
<th>BSN Students (n = 15)</th>
<th>RN to BSN (n = 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Extent</td>
<td>0%</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Somewhat</td>
<td>10%</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Very Little</td>
<td>33%</td>
<td>60%</td>
<td>33%</td>
</tr>
<tr>
<td>Not at all</td>
<td>0%</td>
<td>40%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Before the workshop (Figure 4), most participants indicated they felt somewhat prepared to teach a group including participants in the RN to BSN category. In fact, sixty percent of the RN to BSN students reported very little preparation for group teaching. Only one student in the BSN category felt prepared to a great extent.

**Figure 5. Participants' Perceived Level of Preparation After the Workshop**

*Note:* Of the 20 students who originally agreed to participate in the study, 17 completed the final two surveys and one RN to BSN student returned an incomplete PAS, and was dropped from the Sample reducing the total sample count to 16 for PAS data.
When examining the total sample category after the workshop (Figure 5), 44% of the students reported that they felt prepared to a *great extent* compared to 5% before the workshop. This represents a 39% improvement from the pre-test. Only 12% (two BSN students) answered *very little*, 66% fewer than before the workshop. No one indicated that they did *not* feel prepared *at all*. In the RN to BSN category, no students answered *very little*.

To address the underlying question: Do participants feel prepared for group teaching? *the great extent* and *somewhat* responses were compared to the *very little* and *not at all* responses (See Table 2 for these comparisons).

An affirmative answer could be defined by adding up the percentages of the *great extent* and *somewhat* categories. A negative answer could be defined by totaling the percentages of *very little* and *not at all*. 
Table 2

Answer to the Question: Do Participants Feel Prepared for Their Group Teaching Assignment?

<table>
<thead>
<tr>
<th>Do you feel prepared?</th>
<th>Total Sample</th>
<th>BSN Students</th>
<th>RN to BSN Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before W</td>
<td>55%</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>After W</td>
<td>88%</td>
<td>85%</td>
<td>100%</td>
</tr>
<tr>
<td>Percent Change</td>
<td>60%</td>
<td>42%</td>
<td>150%</td>
</tr>
<tr>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before W</td>
<td>45%</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>After W</td>
<td>12%</td>
<td>15%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Note: Yes=combined percentages of great extent and somewhat; No=combined percentages of Very little and not at all; W=workshop

Before the workshop, half of the participants felt prepared to do group teaching. After the workshop, 88% of the students felt prepared, which represents a 60% percent increase for the total sample. This is consistent in both groups: a 42% percent change in the BSN category and a 150% change in the RN to BSN since students’ answers were all affirmative. However, this might not be applicable to all RN to BSN students since the sample size was very small.
d) Participants’ Perceived Level of Comfort

The PAS was intended to gather data about the participants’ experience in implementing their group teaching assignment. One of the questions was related to their level of comfort in completing their assignment.

Figure 6. Participants' Perceived Level of Comfort After the Workshop
Table 3

Answer to the Question: Did participants Feel Comfortable Implementing Their Group Teaching Assignment?

<table>
<thead>
<tr>
<th>Did you feel comfortable...?</th>
<th>Total Sample</th>
<th>BSN Students</th>
<th>RN to BSN Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>94%</td>
<td>92%</td>
<td>100%</td>
</tr>
<tr>
<td>NO</td>
<td>6%</td>
<td>8%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Note: Yes=combined percentages of great extent and somewhat; No=combined percentages of Very little and not at all

As shown in Figure 6 and Table 3 almost all students felt comfortable in implementing their assignment (94%). Only 6% felt comfortable to a very little extent which represents one student in the BSN category. All students in the RN to BSN category felt comfortable to a great extent.

e) Workshop Evaluation Highlights:

Overall, the workshop was well received:

- 76% of the students found the workshop helpful/very helpful;
- 47% found the format well organized, insightful, well thought out;
41% found the information provided regarding learning styles, cultural differences and learners' motivation very helpful/useful;

35% stated that nothing was not useful;

Answer to the question: “What did you like best about the workshop”?

• 41% the role-play/scenarios;
• 23% the teacher (expertise and enthusiasm);
• 18% appreciated the breaks, dance break and snacks (found it relaxing and re-energizing);
• 6% the material provided (handouts and PowerPoint presentation).

• 29% the interactive part because it allowed individuals to get engaged;
• 29% felt that the theoretical approach helped them, while 23% found the nursing theories activity least useful. Half of these students were in the RN to BSN program.

Other comments included the following:

• “The workshop covered key points to make teaching successful”
"The workshop was well thought out and appealing to all learning styles"

The workshop could have been more beneficial if done in several sessions

The following two questions from the ES are suggestions for the workshop's improvement.

To the question "What other strategies if at all could help you in being better prepared to do group teaching?", 29% answered none. Some of the strategies recommended by students included the following:

- Have more workshops
- Watch a video or presentation of a successful group teaching
- Learn about how to evaluate teaching outcomes
- Strategies on audience appraisal and recognition
- Strategies on group dynamics
- Longer period of time for role-play activity.

To the question "What other information/topic would you have liked covered in the workshop?" 47% answered Nothing "was very thorough". Other information/topics suggested by students included the following:
- Ice breaker, games to loosen people up, better engage them and make them participate
- Role-play in a hospital setting
- Information about where to find good teaching tools and resources
- More visual aids
- Outcome evaluation tools
- One-to-one patient teaching

f) Unexpected Situations:

Students' Group Teaching Assignment Highlights. As shown in Figure 7, most students taught an audience of significant size (nine to 16 participants). The presentations mainly took place in psychiatric (50%) and hospital (31%) settings. The participants ranged in age from two to 82, but 75% were adults between the age of 18 and 82. Most participants were patients (75%) and spoke English (81%).
Figure 7. Participants' Group Teaching Assignment Characteristics

Note: n = 16

Unexpected Situations. 44% of the students experienced unexpected situations as shown in Figure 8.
Did you experience any unexpected situations?

- Yes = 44%
- No = 56%

To what extent did the role-play activity presented at the workshop help you to feel prepared?

- Great Extent = 50%
- Somewhat = 38%
- Very Little = 6%
- Not at All = 6%

Figure 8. About Unexpected Situations

Some of the situations encountered included:

- Patients/clients unresponsive to teaching: low participation rate; unwillingness to hear new information; uncooperative young students; patient fears
- Patients experiencing delusions or hyper mania
- Patients depressed and/or moody
- Patients demanding and/or competitive
- Patient educational background: patient’s incapacity to read resulted in a change of teaching methods and strategy because of patient’s incapacity to read
• Patient upset because did not receive any incentive
• Patient drowsy (medicated just before presentation)
• Patient with short attention span (could not do the proposed activity)

As stated before, 41% of the students liked best the role-play activity. One of the PAS questions addressed the role-play activity during the workshop. Fifty percent of the students felt that the role-play activity presented at the workshop helped them feel prepared to a great extent and 38% somewhat prepared (see Figure 8).

Discussion

The Study Design

The research was intended as a pilot study to determine if a workshop could be worthwhile to help baccalaureate nursing students to be better prepared for their group teaching assignment and how it could be done in two CSUSB undergraduate nursing programs at PDC. The investigator made the workshop available to students and asked them what they thought about it and how they felt when they did their group teaching assignment (PAS and ES). The investigator also asked the students to share their
perceptions about group teaching knowledge, before and after the workshop (PIF, pre- and post-tests). The investigator hoped the study results could be used as a baseline to implement a future larger study. A pilot study is usually used to test the methods and processes of a larger study on a smaller scale, also called parent study. It ensures that all the components of the study works well together (Arain, Campbell, Cooper, & Lancaster, 2010; Polit & Beck, 2008). On the other hand, feasibility studies are used to refine important parameters of a main study design. They are not necessarily implemented on a smaller scale but their purpose is to provide precise information to avoid undertaking an expensive but fruitless larger study (Arain, Campbell, Cooper, & Lancaster, 2010; Polit & Beck, 2008). Arain, Campbell, Cooper and Lancaster (2010) and Teijlingen and Hundley, (2002) argue that pilot studies are often under reported, mislabeled and assimilated to feasibility studies that the authors attribute to an inappropriate emphasis on hypothesis testing.

According to these definitions, the group teaching study can be categorized as a hybrid version: the study is a pilot in the sense that it was conducted for the first time with the PDC students when a larger study including
the entire cohort of CSUSB undergraduate nursing students would be necessary to provide representative data and analyze specific patterns among categories of students.

It is a feasibility study as well, given that the circumstances experienced while implementing this study brought to light information about elements to consider in order to repeat the study successfully. For instance, the organization of students' meetings for clinical hours (days, time, student group) differed tremendously from one course to another. This significantly weighed on the workshop attendance and final number of study participants. Several meetings must take place with the courses' coordinator, didactic and clinical instructors to meticulously organize the students' schedules in a way that would allow them to participate without disturbing their regular courses or adding burden to their already full schedules. In addition, the group teaching preparation should be part of the course and refer to the program curriculum. In the case of the present study, time constraint and last-minute administrative changes did not allow such organization. Fortunately, after the pilot study was completed, the investigator and the instructors met to
to discuss the effect of the workshop on the curriculum and students' school work load.

The Sample Size

The final study sample size was rather small. Although the workshop was offered to approximately 60 students enrolled in N405, N401 and N220 in the Spring Quarter 2010 at PDC, only 31 attended (52%). The opportunity for participation in the study was only given to workshop attendees. Perhaps this low response rate indicates a relationship between the number of participants and students' belief in the importance of their teaching role in nursing.

Sixty-four percent of the attendees agreed to participate in the study, which is not far from the 70% compliance rate usually accepted by journal editors (Hopkins, 2008). In the study of Kowalski, Horner and Houser (2011), although the sample size is much larger—three hundred forty-two nurses workshop attendees—the response rate was similar (66% which equal to 226 surveys returned. Additionally, Thabane et al., (2010) explain that the sample for a pilot should be representative of the
target study population and the sample large enough to provide significant data to evaluate feasibility.

RN to BSN students represented 25% of study participants (n = 5). This number is not representative of the quarter's RN to BSN cohort since about 16 students were enrolled in N405 at that time. Therefore, the data obtained for this category cannot be generalized to the BSN category, nor is it applicable to the rest of the RN to BSN cohort. Besides, the occurrence of other concomitant studies in the nursing department raised the question of study participant burden. In future studies, participant burden should be considered within the nursing department and the group teaching preparation proposed in a way that facilitates participation.

Participants' Perceived Knowledge

The post-test results indicated a 42% percent change in the highest score the day of the workshop. The use of pre- and post-tests are appropriate to measure participants' knowledge. Pre- and post-tests are particularly useful to evaluate what participants learn from the workshop content. The information also allows the instructor to adjust the training content if necessary (I-TECH, 2010).
Similar studies such as the quasi-experimental study by Carpenter and Bell (2002) showed similar results. The authors evaluated the teaching knowledge of 44 nurses of a community hospital after providing a one and one-half hour intervention on the teaching process. This intervention was initiated after an investigation conducted in the hospital revealed "ineffective patient education sessions due to lack of knowledge and use of the teaching process in healthcare settings" (p. 158). According to the authors, the study participants had never received formal training in patient education even though half of the sample had a BSN degree and one had an MSN degree. They received identical pre- and post-tests the day of the intervention.

Two months later, a small sample (10 nurses) completed a follow-up test on the teaching process. The authors reported an increase of 0.4 points from the pre-test mean of 7.7 to a post-test mean of 8.3 using a t-test. The follow-up test results showed a mean of 7.4, which is lower than the first mean. An interesting fact was that "motivation or perceived significance of the participant to learn the teaching process" (p. 161) and the effective time of the teaching intervention (1.5 hours) were cited as limitations of the study. When compared to the group
teaching study, the participants’ post-test scores also showed an increase in knowledge but the follow-up suggested greater needs in terms of follow-up teaching training and evaluation. This decrease of motivation and knowledge over time goes along with the argument developed by Ball and Forzani (2009) regarding the necessity of closed training, practice and detailed professional preparation for proper teaching and the common resistance to learn how to do it well.

Although the findings of the Carpenter and Bell study appear to be biased (small size, especially of the follow-up group), it does highlight the issue of nurses’ lack of knowledge in teaching and the controversy about nurses’ belief about teaching as part of the nursing role.

About the Participants Perceived Level of Preparation and Level of Comfort

In the group teaching study, the perceived level of preparation and level of comfort were measured with a four-point likert scale. This type of scale is recommended to measure attitudes, uses a range of rating items (Cohen, Manion, & Morrison, 2000) and is often used in nursing research.
Lamiani and Furey (2009) conducted a two-day workshop on patient education using the patient-centered model as a framework. The researchers wanted to examine nurses’ (1) perceived sense of preparation; (2) knowledge on patient education process; and (3) communication skills. The investigators used a five-point likert scale and questions in yes/no format to measure nurses’ sense of preparedness and self reported knowledge (patient centered model, teaching process). Fourteen nurses attended the two-day workshop on patient education. The study results showed an improvement in nurses’communication skills, patient-centered knowledge and perceived sense of preparedness. The study investigators had an interesting use of the pre-post test design. To evaluate impact of the workshop on communication skills (Lamiani & Furey, 2009) collected written dialogue that nurses were supposed to write in 15 minutes from a scenario as pre- and post tests. The dialogue analysis was made using the Roter Interaction Analysis System, quantitative analysis validated tool to measure nurse-patient communication (2009). Little (2006) also used a Likert-scale questionnaire to examine students’ perceptions of the teaching-learning workshop.
According to Perry (2011), confidence and self-confidence are critical in nursing practice. Nurses are unlikely to step in the role of nurse educator if they do not feel confident about their ability to provide patient education (Noble, 1991). Perceived-self confidence was studied by Donner et al. (2005); Liaw, Scherpbier, Rethans and Klainin-Yobas (2011) and Perry (2011). These authors demonstrated the positive or negative influence of self-confidence in the nursing practice, particularly in the educator role of nurses. The measure of perceived level of comfort in the group teaching study was an attempt to examine the perceived level of confidence. In future studies, the term comfort will be substituted for confident to match the current nursing research trend.

The Theoretical Approach

- 29 % like best the interactive part because it allowed individuals to get engaged;

- 29 % felt that the theoretical approach helped them, while 23 % found the nursing theories activity least useful of which 50% were RN to BSN students.

The learning theories were presented during an interactive activity that consisted first, in answering
questions related to how people learn, their motivation to learn and motivation for behavior change (Appendix E, p. 99) and then matching the answers provided to the most appropriate learning theory after listening to the description of each theory. The success of this activity was based on the students’ participation, which worked well with two groups. In one of the groups, the activity ended up being more like a lecture due to the students’ low participation. This represents one limitation of the study in that even though the same content was provided, the workshop was not presented to all students at the same time. It is interesting to observe the variety of answers to the question, What did you like best about the workshop. This demonstrates the importance of considering all learning styles when teaching groups. Felder (1996) recommends ensuring that the learning needs of students be met in each learning style and model at least part of the time. He refers to it as “teaching around the cycle” (p.1).

Unexpected Situations During a Teaching Event

Often, even with the best preparation, things do not happen according to plan. Like most educators nurse must live up to this challenge daily. Longo and Tierney (2012) consider that preparation and professionalism are the main
strategies to handle these situations. As described by the

group teaching study participants, unexpected situations

for a nurse educator could be as dramatic as a patient

experiencing delusions or depression. This is quite
different than just dealing with presenting a prepared
topic. Teaching to a group in a community health, hospital

or psychiatric setting increases the probability of facing
these types of situations even more. Although there are

extensive articles and research on health education and
teaching, not much is said in the literature about how to

handle these types of situations and how to implement group
teaching specifically. Yet it is expected that nurses

instinctively will do this.
CHAPTER FIVE
CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The purpose of this pilot study was to describe the impact of a group teaching preparation on Baccalaureate nursing students’ perceived knowledge, level of preparation and level of comfort regarding group teaching.

The preparation was proposed in the form of a workshop that was successful: 76% of the participants found it helpful. The participants’ perceived knowledge increased after the workshop. The median improved (score of 11 correct answers out of 12 after the workshop compared to 10 correct answers before), and there was a 42% percent change in the 100% post-test score. Eighty-eight percent of the participants felt better prepared compared to 55% before the workshop and 94% felt comfortable in implementing their assignment.

Participants reported learning and beginning to reflect on the elements to consider when teaching challenged clients. Students who experienced unexpected situations during their presentation were able to manage them. Participants expressed an interest in
receiving more instruction about group teaching and teaching in general, in their feedback. The workshop appeared to be a motivating way to help nursing students prepare to teach groups of clients (47% of the participants appreciated it and found it well organized).

The study was also well received among the CSUSB nursing faculty and provided an opportunity for a rich discussion about the topic in general and the possibility of including a teaching component in the BSN and RN to BSN programs' future curricula.

Limitations of the Study

The Sample Size

The sample size of the RN to BSN student category represents a selection bias. A larger sample in this category could have allowed more in-depth analysis of the differences between the two categories of students.

Last-minute Unforeseen Administration Changes

A lower-than-expected number of enrolled students in the two programs resulted in a smaller number of students per class and a change of course instructors. Consequently, the necessary time for meeting with the new instructors to discuss the study modalities was considerably reduced
causing coordination challenges. Moreover, the investigator had to modify the study design from a quasi-experimental study to a descriptive study after Institutional Review Board (IRB) reapproval. The original design included a control group.

**Study Instrument Design**

The formulation of the PAS and ES could have been more precise. Many of the questions of these surveys were open-ended questions, which provided extensive qualitative data. Perhaps using Likert scales for all survey questions, could have allowed the investigator to collect more quantitative data while giving participants the opportunity to comment in their own words by using additional open fields.

The question about the level of comfort was meant to address study participants’ perceived level of confidence. To avoid misinterpretation, the term *comfort* was maintained as such. In future studies, the term *comfort* will be substituted for *confident*. The question will be asked before the workshop as well, to allow comparison with the post-workshop data.

Another element to keep in mind in designing a study is simplicity. The use of two final surveys may have
confused some of the students such as the RN to BSN student who did not complete the PAS but completed the ES and indicated that the workshop was beneficial to her. Combining the PAS and ES in one four-point Likert scale survey with a few open fields for comments could eliminate some of the confusion. It could also provide an opportunity to refine the questions and elude duplicate or too similar questions. Participants’ feedback could also be collected in a focus-group format.

**Time and Distance Constraints**

Students were not available all at once; therefore, the workshop was presented at three different times. As previously explained, this created a bias since the participants did not hear the workshop content at the same time. Although great effort was made to provide the same content at all sessions, it is impossible to certify that it was provided exactly the same way considering that groups dynamics differ.

**Recommendations and Lessons Learnt**

A larger-scale study is feasible with re-visititation of the issues previously mentioned. The study can be repeated with a larger sample size. A longitudinal design could
allow the investigator to learn about the impact of the group teaching preparation in the participants' nursing practice.

A core health education course with competencies could be included in the baccalaureate nursing programs and the students' knowledge and skills evaluated. This could be a complimentary study with an experimental design (control group). An easy alternative could be to review the workshop content and videotape it. This would (1) allow students to learn the tedious aspects of the workshop at their own pace and (2) leave more face-to-face time available for role-play scenarios activity. Little's (2006) study results showed positive feedback from study participants about the use of videotaping as a self-assessment and peer review tool.

The workshop itself was an illustration of what was taught (variety of teaching methods, learning styles, unexpected situations and so on). This could be another type of study, as the investigator becomes a participant-observer.

The study was successful. It mostly fit the criteria for a pilot study: the results highlighted the necessary
changes and elements to take into consideration to make a larger study successful.

One of the most important lessons learnt was the necessity of proper communication and coordination with the faculty. There are administrative changes beyond anyone’s control. Frequent communication can help trouble-shoot these unexpected situations. In addition, steps to implementation always take much longer than anticipated.

Another lesson came from informal discussions with the students. Some of them had to cope with challenging situations as stressful as their clients’. To increase the number of study participants, it is important to simplify every step as possible.

Conclusion

Teaching is a process very similar to the nursing process (Close, 1988; DeYoung, 2009). A process is defined as “a series of actions or operations conducing to an end” (Merriam-Webster Online Dictionary, 2012). This implies that it requires time and repetition for one to master (life-long process).

Learning is also a process and an active one. Children learn by repetitive patterns with complex sequential
neuronal activity (Perry, 2006) and so do adults. Nurses are no different. They are not divinities or magicians. They are individuals with advanced critical thinking skills. Trained to assess, diagnose, identify outcomes, plan, implement and evaluate, they render unique and specific services to communities in all types of settings. Nurses are above all, strong leaders and advocates for the greater good of individuals and communities. Providing health education is inherent to nursing. It is essential in today’s healthcare and economic crisis context, and it is expected for nurses to be expert in health education (Bastable, 2008; Little, 2006).

Nationwide efforts in prevention create a unique opportunity for nurses and workers in the field of public health to advocate and bring evidenced-based information to the political tables at all levels (local, state and federal). It is the author’s belief that like the emerging concept of “health in all policies”, health education (key health messages) should be promulgated everywhere to provide multiple opportunities for individuals and their families to grasp the information and make informed decisions about their health. The future of nursing is at stake when undergraduate nursing programs have to
compromise to provide the basic components of the profession because of budget cuts. Yet, it is still the schools of nursing's responsibility to provide appropriate knowledge and skills so that nurses are properly prepared and equipped to answer individuals' and communities' needs.

The weight of responsibility rests on the nursing faculty's shoulders. The results of the group teaching study provided food for thoughts and tangible material to envision a basic teaching and learning component in the BSN and RN to BSN programs future curricula. The participants and faculty's response to this study give great hope for future studies.
APPENDIX A

STANDARDS OF COMPETENT PERFORMANCE

CALIFORNIA NURSING PRACTICE ACT

CALIFORNIA CODE OF REGULATIONS

TITLE 16
Section 1443.5 (3) A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

- performs skills essential to the kind of nursing action to be taken
- explains the health treatment to the client and family
- teaches the client and family how to care for the client's health needs

Comments/Notes:
This section of the NPA authorizes many of the independent nursing functions the RN performs based on pre-licensure educational preparation and RN license in California.

Reference:
California Nursing Practice Act: standards of competent performance California code of regulations title 16, § 1443.5 (2). Retrieved April 17, 2011 from http://leginfo.ca.gov/cgi-bin/waisgate?WAISdocID=13239412684+0+0+0&WAISaction=retrieve

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APPENDIX B

NATIONAL PREVENTION STRATEGIES HIGHLIGHTS
The National Prevention Strategy
The National Prevention Strategy aims to guide our nation in the most effective and achievable means for improving health and well-being. The Strategy prioritizes prevention by integrating recommendations and actions across multiple settings to improve health and save lives.

The National Prevention Strategy's vision is Working together to improve the health and quality of life for individuals, families, and communities by moving the nation from a focus on sickness and disease to one based on prevention and wellness.

This Strategy envisions a prevention-oriented society where all sectors recognize the value of health for individuals, families, and society and work together to achieve better health for all Americans.

The National Prevention Strategy's overarching goal is Increase the number of Americans who are healthy at every stage of life.

This Strategy focuses on both increasing the length of people's lives and ensuring that people's lives are healthy and productive. Currently Americans can expect to live 78 years, but only 69 of these years would be spent in good health. Implementing the National Prevention Strategy can increase both the length and quality of life. To monitor progress on this goal, the Council will track and report measures of the length and quality of life at key life stages (Appendix 2 for baselines and targets). To realize this vision and achieve this goal, the Strategy identifies four Strategic Directions and seven targeted Priorities. The Strategic Directions provide a strong foundation for all of our nation's prevention efforts and include core recommendations necessary to build a prevention-oriented society. The Strategic Directions are

- Healthy and Safe Community Environments: Create, sustain, and recognize communities that promote health and wellness through prevention.
- Clinical and Community Preventive Services: Ensure that prevention-focused health care and community prevention efforts are available, integrated, and mutually reinforcing.
- Empowered People: Support people in making healthy choices.
- Elimination of Health Disparities: Eliminate disparities, improving the quality of life for all Americans.

Within this framework, the Priorities provide evidence-based recommendations that are most likely to reduce the burden of the leading causes of preventable death and major illness. The seven Priorities are

- Tobacco Free Living
- Preventing Drug Abuse and Excessive Alcohol Use
- Healthy Eating
- Active Living
- Injury and Violence Free Living
- Reproductive and Sexual Health
- Mental and Emotional Well-Being

Moving Forward
National leadership is critical to implementing this Strategy. This leadership includes aligning and focusing Federal prevention efforts. However, the Federal government will not be successful acting alone. Partners in prevention from all sectors in American society are needed for the Strategy to succeed. All of us must act together, Implementing the Strategic Directions and Priorities, so that all Americans can live longer and healthier at every stage of life.
Empowered People

Although policies and programs can make healthy options available, people still have the responsibility to make healthy choices. People are empowered when they have the knowledge, ability, resources, and motivation to identify and make healthy choices. When people are empowered, they are able to take an active role in improving their health, support their families and friends in making healthy choices, and lead community change.

KEY FACTS

- Health information is often presented in a way that many Americans find difficult to understand and put into action. Nearly 9 in 10 adults have problems using the health information available to them in health care facilities, retail outlets, media, and communities.

- A person’s decisions are influenced by how choices are presented (i.e., choice architecture). For example, presenting fruit in a more attractive way to school children can more than double the amount of fruit they purchase.

- Discrimination, stigma, or unfair treatment in the workplace can have a profound impact on health. For example, discrimination can increase blood pressure, heart rate, and stress, as well as undermine self-esteem and self-efficacy.

- Education, employment, and health are linked. Without a good education, prospects for a stable and rewarding job with good earnings decrease. Education is associated with living longer, experiencing better health, and practicing health-promoting behaviors such as exercising regularly, refraining from smoking, and obtaining timely health checkups and screenings.

Recommendations: What Can Be Done?

1 Provide people with tools and information to make healthy choices. Information needs to be available to people in ways that make it easy for them to make informed decisions about their health. Providing people with accurate information that is culturally and linguistically appropriate and matches their health literacy skills helps them search for and use health information and adopt healthy behaviors. For example, providing people with information about the risks and benefits of preventive health services can motivate them to seek preventive care. Providing people with information (e.g., nutrition information on menus and food product labels) can help increase demand for healthy options and may influence supply, because companies are more likely to provide healthy options when they perceive consumer demand for such products.

2 Promote positive social interactions and support healthy decision making. Interactions with family members, friends, and coworkers, involvement in community life, and cultural attitudes, norms, and expectations have a profound effect on the choices people make and on their overall health. Enhanced social networks and social connectedness (e.g., through volunteer opportunities, transportation services, or workplace safety and health initiatives) can help encourage people to be physically active, reduce stress, eat healthier, and live independently. Mass media and social media can be used to help promote health and well-being. Individuals’ decisions are influenced by how environments are designed and how choices are presented. Small changes to the environment in which people make decisions can support an individual’s ability to make healthy choices. For example, making stairwells more attractive and safe increases their use and placing healthy options near cash registers can increase their likelihood of purchase.

3 Engage and empower people and communities to plan and implement prevention policies and programs. Providing people with tools and skills needed to plan and implement prevention policies and programs can help create and sustain community change. Effective public participation can help ensure that health equity and sustainability are considered in decision making.
(e.g., community planning, zoning, and land use decisions). Community coalitions can be effective in raising awareness and attention to a broad range of issues (e.g., alcohol and other substance abuse, teen pregnancy, cancer prevention and control) and implementing effective policies and programs.

4 Improve education and employment opportunities. Without employment and education, people are often ill-equipped to make healthy choices. Education can lead to improved health by increasing health knowledge, enabling people to adopt healthier behaviors and make better-informed choices for themselves and their families. Employment that provides sufficient income allows people to obtain health coverage, medical care, healthy and safe neighborhoods and housing, healthy food, and other basic goods. Employment can also influence a range of social and psychological factors, including sense of control, social standing, and social support. Programs and policies to reduce high school dropout rates, make advanced education more affordable, and promote job growth and quality can have a large impact on people’s ability to make healthy choices.

**Actions**

**The Federal Government will**
- Identify and address barriers to the dissemination and use of reliable health information.
- Use plain language in health information for the public in alignment with the Main Writing Act.
- Support research and evaluation studies that examine health literacy factors in the study of other issues (e.g., patient safety, emergency preparedness, health care costs).
- Work to reduce false or misleading claims about the health benefits of products and services.
- Support research and programs that help people make healthy choices (e.g., understand how choices should be presented).

**Partners Can**

State, Tribal, Local, and Territorial Governments can
- Create healthy environments that support people's ability to make healthy choices (e.g., smoke-free buildings, attractive stairwells, cafeterias with healthy options).
- Offer accurate, accessible, and actionable health information in diverse settings and programs.

Businesses and Employers can
- Implement work-site health initiatives in combination with illness and injury prevention policies and programs that empower employees to act on health and safety concerns.
- Use media (e.g., television, Internet, social networking) to promote health.

Health Care Systems, Insurers, and Clinicians can
- Use proven methods of checking and confirming patient understanding of health promotion and disease prevention (e.g., teach-back method).
- Involve consumers in planning, developing, implementing, disseminating, and evaluating health and safety information.
- Use alternative communication methods and tools (e.g., mobile phone applications, personal health records, credible health websites) to support more traditional written and oral communication.
- Refer patients to adult education and English-language instruction programs to help enhance understanding of health promotion and disease prevention messages.

Early Learning Centers, Schools, Colleges, and Universities can
- Provide input, guidance, and technical assistance to state, tribal, local, and territorial health departments in assessing health impacts and conducting comprehensive health improvement planning.
- Incorporate health education into coursework (e.g., by embedding health-related tasks, skills, and examples into lesson plans).

<table>
<thead>
<tr>
<th>Key Indicators</th>
<th>Current</th>
<th>10-Year Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of persons who report their health care provider always explained things so they could understand them</td>
<td>60.0%</td>
<td>66.0%</td>
</tr>
<tr>
<td>Proportion of adults reporting that they receive the social and emotional support they need</td>
<td>80.0%</td>
<td>88.0%</td>
</tr>
</tbody>
</table>
Empowered People

Community, Non-Profit, and Faith-Based Organizations can
- Empower individuals and their families to develop and participate in health protection and health promotion programs through neighborhood associations, labor unions, volunteer/service projects, or community coalitions.
- Identify and help connect people to key resources (e.g., for health care, education, and safe playgrounds).
- Support and expand continuing and adult education programs (e.g., English language instruction, computer skills, health literacy training).

Individuals and Families can
- Actively participate in personal as well as community prevention efforts.
- Participate in developing health information and provide feedback regarding the types of health information that are most useful and effective.
- Provide clinicians with relevant information (e.g., health history, symptoms, medications, allergies), ask questions and take notes during appointments, learn more about their diagnosis or condition, and follow up with recommended appointments.

KEY DOCUMENTS
- National Action Plan to Improve Health Literacy
- Questions are the Answer
- Health Literacy Online
- Healthfinder.gov (http://www.healthfinder.gov)

PROJECT HIGHLIGHT: Active Living by Design: Albuquerque, New Mexico
Working to create community-led change, Active Living by Design helps support individual's choices to eat healthier and increase physical activity. Albuquerque's Healthy Eating School-Based Partnership includes school districts, individual schools, and local farmers working to increase student, parent, and teacher consumption of fresh fruits and vegetables by expanding access to locally grown produce.

Reference:
Gouvernment Printing Office. Retrieved from
http://www.healthcare.gov/prevention/nphpphc
/strategy/report.html
APPENDIX C

PUBLIC HEALTH IN AMERICA STATEMENT
Vision:
Healthy People in Healthy Communities

Mission:
Promote Physical and Mental Health and Prevent Disease, Injury, and Disability

Public Health

- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery
- Assures the quality and accessibility of health services

Essential Public Health Services

- Monitor health status to identify community health problems
- Diagnose and investigate health problems and health hazards in the community
- Inform, educate, and empower people about health issues
- Mobilize community partnerships to identify and solve health problems
- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and ensure safety
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assure a competent public health and personal health care workforce
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Research for new insights and innovative solutions to health problems
Adopted: Fall 1994, Source: Public Health Functions Steering Committee, Members (July 1995):
American Public Health Association-Association of Schools of Public Health; Association of State and Territorial Health Officials; Environmental Council of the States; National Association of County and City Health Officials; National Association of State Alcohol and Drug Abuse Directors; National Association of State Mental Health Program Directors; Public Health Foundation; U.S. Public Health Service -- Agency for Health Care Policy and Research; Centers for Disease Control and Prevention; Food and Drug Administration; Health Resources and Services Administration; Indian Health Service; National Institutes of Health; Office of the Assistant Secretary for Health; Substance Abuse and Mental Health Services Administration

Reference:


Public Health in America. Retrieved from

http://www.health.gov/phfunctions/public.htm
APPENDIX D

TEACHING STRATEGIES FOR SUCCESSFUL

GROUP TEACHING WORKSHOP AGENDA
Teaching strategies for successful group teaching

Workshop Agenda

Introduction:
- Welcome words
- Workshop objective
- Study presentation
- Forms and pre-test completion

Part I: Nurses as Educators
1) Importance of patient education in current healthcare system
2) Theoretical approach
3) Concept of learning and what it involves

Part II: Basic group teaching notions:
1) Elements to take in consideration
   - Learning styles
   - Cultural differences
   - Participant motivation
2) Preparation
3) Teaching methods:
   - Traditional
   - Innovative: "Thinking outside the box..."

Break 15 minutes

Part III: “What if...?”
- Role-play scenarios
- Discussion

Questions

Post-test completion

Adjourn

Developed by Nathalie Confiac (April 2011).
APPENDIX E

TEACHING STRATEGIES FOR SUCCESSFUL

GROUP TEACHING WORKSHOP

POWERPOINT PRESENTATION
Teaching strategies for successful group teaching

Nathalie Coughlin, PHN, RN
MSN student
California State University San Bernadino

WORKSHOP OBJECTIVES

- Describe group teaching basic notions
- Describe the different teaching methods in approaching patient groups
- Describe teaching strategies to be successful even in unexpected situations
- Successfully complete a group teaching assignment
Nurses as Educators

HEALTH CARE CRISIS

- Unaffordable Health insurance
- Outrageous healthcare costs
- Alarming health outcomes (obesity epidemic, CVA rates)
- Capacity issues (infrastructure, nursing shortage)
- Limited Funds
WHAT ARE GOING TO DO?

Teach people how to take care of themselves
BECAUSE

- Many diseases are preventable
- Many health issues are associated or depends on lifestyles and behaviors choices
- We have no more money left or capacity to take care of them
Levels of Prevention

- **Primary Prevention**
  - Protect and Promote Health
  - Prevent diseases

- **Secondary Prevention**
  - Early detection of diseases
  - Early treatment of diseases

- **Tertiary Prevention**
  - Reduce long-term complications
  - Prevent disabilities

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**Importance of Patient Education in Nursing**

- Nursing role: CA nursing practice Act
- Healthy people 2010 and 2020
- One of Public health essential services (Public health in America)
THEORETICAL APPROACH

- How do people learn?
- What motivates people in learning new things?
- How does the information provided help people modify their behavior?
- What motivates/prevents people in behavior modification?

LEARNING THEORIES

- Behaviorist
- Cognitive
- Social Learning
- Psychodynamic
- Humanistic
Basic group teaching notions

THE UNNATURALNESS OF TEACHING

- Difference between being an expert in a topic and being able to teach it
- Teaching others implies seeing ideas and skills from others' perspective
- Do not assume you are understood

Loewenberg & Forzani (2010-2011)
ELEMENTS TO TAKE IN CONSIDERATION

- Learning styles
- Cultural differences
- Participants motivation

PREPARATION

- Teaching topic,
  - Backward design
    (Wiggins and McTighe, 2005)
- Materiel logistic
A FEW LEARNING PRINCIPLES

- Actively involve the learner in the learning process
- Provide a conducive environment
- Assess Readiness to learn
- Begin with what is known, move towards what is unknown
- Repeat the information
- Present information at an appropriate rate (speed)
- Make learning a pleasant experience

TEACHING METHODS

Traditional | Think outside the box
---|---
Lecture | Games
Group discussion | Role-playing
One to One | Movies/videos
Demo/return | Simulation
Role modeling | Songs
Powerpoint presentation developed by Nathalie Confiac (May 2011). Pictures are from 2011 office for Mac powerpoint clipart gallery.
APPENDIX F

TEACHING STRATEGIES FOR SUCCESSFUL

GROUP TEACHING ROLE PLAY-SCENARIOS
Group Teaching Workshop
Role Play Scenarios

Scenario 1:
You are teaching to a support group of 5 new mothers. The topic of the day is post partum depression. When discussing the topic of family support, one participant burst in tears. What do you do?

Scenario 2:
You are teaching a group of 25 clients at a Psychological Center about recovery, wellness and resilience. You are discussing the importance of taking prescribed medications regularly to maintain wellness when two participants start to argue and take over the discussion. What do you do?

Scenario 3:
You are invited to teach a nutrition class to a group of high school students. You are very excited about your topic: “How to increase fruits and vegetables consumption”. You have planned to use food models, show a video, and do interactive games with the 20 participants. When you introduce the session half of the students start to sigh and yawn while the others express strong disinterest in the topic. However, one participant has specific questions on Hirschsprung disease, which you are not really familiar with. What would you do?

Scenario 4:
You are teaching a small group of young mothers about stress control at a community center. The participants are well-engaged in the discussion, and an animated debate focusing on the importance of physical activity is taking place. You suddenly realize that you only have 15 minutes left before the end of the allowed time for the class. You have only covered a fourth of the topic. What do you do?

Scenario 5:
You are invited to talk about the effects of cigarette smoke on one’s general health in a psychological center where a free wellness class is organized bi-monthly. You have planned a PowerPoint presentation, an online video document and role-play games in which participants will be divided in groups of five. You had previously visited the classroom and met the technician. When you arrive, the technician tells you that there is no available computer and the Internet connection is down. At the time of the presentation only five people have shown up. What do you do?

Scenario 6: Discussion
You are asked to start and lead a parenting (or wellness class) in a rural community. The coordinator informs you that the potential participants would include people with varying cultural identities: 3/5 Mixtecos, 3 Puerto Ricans, 6 Mexicans, 5 American Caucasians, 2 African-Americans. What are items that could be discussed with the coordinator? How would you organize the sessions?

Developed by Nathalie Confiac (January-March 2011).
APPENDIX G

TIPS FOR GROUP TEACHING SUCCESSFUL
MANAGEMENT OF UNEXPECTED SITUATIONS
Clients' response to teaching topics

Cultural challenges

Unexpected events

Clients with disabilities

Opening of the teaching session
Welcome words, ground rules, housekeeping.
Summary of main point covered: timeframe, learning objectives, time for questions

Client's perspective on topic:
- Analyze participant's feelings.
- "Cultural challenges remaining"
- Step into the classroom.
- Identify problems.
- Work with participant right after class.
- Make a systematic approach.

Participant's perspective on topic:
- Acknowledge participant's interest and note his/her questioning.
- Protect to develop topic at a later session.
- Meet client right after class or text.
- Give resource materials and make referrals as needed.

Little modifying:
- Use a flip chart.
- Play music, health walks, etc.
- Use key words, drawings, gestures, and materials already translated in the language.
- Ask another regular participant to assist you in translating (after providing specific guidelines).
- Side-line, de-escalation if necessary.

Little modifying:
- You are missing electronic materials simple to better use alternate material to match all learning styles.
- It is possible to plan a discussion and measurable exercises.

Personal Comments:

Developed by Nathalie Confiac (February 2011).
APPENDIX H

GROUP TEACHING STUDY INFORMED CONSENT FORM
Nathalie Conflac: Group Teaching Study

INFORMED CONSENT FORM

The study in which you are being asked to participate is designed to assess nurses’ group teaching skills. This study is being conducted by Nathalie Conflac, PHN, RN, graduate student at the California State University, San Bernardino (CSUSB), under the supervision of the graduate thesis committee members: Teresa Dodd-Butera, RN, MSPH, PhD, DABAT; Margaret Beaman, PhD, RN and Susan McGee-Stehsol, RN, MSN. This study has been approved by the CSUSB Institutional Review Board.

PURPOSE:
The purpose of the study is to improve nurses’ group teaching skills; and, in addition, present teaching strategies for successful group teaching.

DESCRIPTION:
The study will be conducted throughout the Spring quarter 2011, as part of your clinical course assignments. Your participation will consist of:

1) Attending a 3-hour workshop.
   During the workshop you will be asked to
   a) Sign the consent form
   b) Complete the Group Teaching Study Participant Information Form, upon signature of the consent
   c) Complete the Group Teaching Workshop Pre-test
   d) Complete the Group Teaching Workshop Post-test

2) Completing a group teaching assignment. You will have a period of 4 weeks following the workshop to complete this assignment.

3) Completing the Group Teaching Post Assignment Survey and Group Teaching Study Exit Survey during a one-hour final meeting.
   -The workshop, Pre-test, Post-test and Post Assignment Survey are part of your course requirements and are activities for all students.

Only the data of students participating in the study will be used.
Only study participants will complete the Group Teaching Study Participant Information Form and Group Teaching Study Exit Survey.

-You will receive clinical hours for your participation in the study activities. You will also receive a folder with educational resources the day of the workshop. Dinner or lunch, snacks and drinks will be offered the day of the workshop and at the final meeting.

PARTICIPATION:
Your participation is voluntary. No penalty will be incurred if you refused to participate in the study. You may withdraw from the study at anytime. If you choose to do so your extra hours for clinical will be prorated to time of participation.
Your instructor will not be informed of your participation in the study. Only the investigator will have access to consent forms. All students will receive the documents to be completed at the same time and will return them to the investigator.

909.537.5380 • fax: 909.537.7089 • http://nursing.csusb.edu
5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CA 92407-2393
The Group Teaching Study Participant Information Form and Group Teaching Study Exit Survey will be returned completed by study participants and blank by non-participants. Information from the Group Teaching Post Assignment Survey may be used by the instructor to evaluate the effectiveness of the teaching assignment. The instructor will receive a copy of all students Group Teaching Post Assignment Survey and will not be able to know the identity of students participating in the study.

CONFIDENTIALITY:
Your participation and personal information are confidential. The personal information collected for the study will be strictly used for the purpose previously described. The data shared will exclude any names or other personal identifiers. To maintain confidentiality, you are asked not to disclose your decision regarding participation in this study to your instructor or classmates.

You are provided with two consents forms that must be signed. One is to be returned and the other one is for you. Both must be signed.

DURATION: The expected duration of your participation is the Spring 2011 quarter.

RISKS:
Risks are minimal and may include psychological discomfort that could be associated with role-plays during the workshop. You will be free to participate or not in the role-play scenarios.

BENEFITS:
Benefits include professional knowledge and skills improvement, peer sharing, clinical hours credits, dinner or lunch, snacks and drinks the day of the workshop and final meeting.

CONTACT:
If you need additional information you may contact Nathalie Conflac at 805-452-5429 or at conflac@coyote.csusb.edu; or Teresa Dodd-Butera, PhD, RN/DABAT at 619-995-4057; you may also email her at tdbutera@csusb.edu.

RESULTS:
The results of the study will be available to you at the time of release of the thesis in September 2011 at the Department of Nursing.

SIGNATURE:
I have read the above description and give my consent for the participation in this study

Signature: ____________________________ Date: __________

I have read the above description and do not wish to participate in this study

Signature: ____________________________ Date: __________
APPENDIX I

GROUP TEACHING STUDY PARTICIPANT

INFORMATION FORM (PIF)
Nathalie Confiac—Group Teaching Study
Participant Information Form

Full Name: __________________________________________

Email: ____________________________________________

Age: _______

Sex:

☐ Male

☐ Female

What is the Zip Code of the city where you live? ___________

What is your title or profession? ________________________________

How long have you been a nurse (if applicable)? _______________________

Please select the choice that best describes your work setting?

☐ Hospital

☐ Public Health

☐ Education

☐ Community organization

☐ Childcare organization

☐ Other: _______________________

Which program are you currently attending? _______________________

How long have you been in the nursing program? _______________________

Have you taught to groups before? _______________________

Do you currently do any group teaching? _______________________

To what extent do you feel prepared to teach in a group setting?

☐ Great Extent

☐ Somewhat

☐ Very Little

☐ Not at All

Developed by Nathalie Confiac (February 2011).
APPENDIX J

GROUP TEACHING PRE- POST-TEST
Nathalie Confic — Group Teaching Pre-test

Directions: Please circle the correct response to the following questions.

1) Behaviorist, Cognitive, Social Learning and Humanistic are examples of learning theories.
   a) True
   b) False

2) Lecture, Group discussion, Games and movies are examples of teaching methods.
   a) True
   b) False

3) Auditory, Visual, Kinesthetic are
   a) Part of human-being sensory system
   b) Learning styles
   c) Part of human beings abilities
   d) All of the above
   e) None of the above

4) When preparing for a group teaching it is important to take in consideration:
   a) Participants learning styles
   b) Participants moods
   c) Participants cultural backgrounds
   d) Participants level of knowledge and motivation
   e) a, c & d

5) You are teaching a support group of five new mothers. The topic of the day is postpartum depression. When discussing the topic of family support systems, one participant bursts into tears. Which of the following is most appropriate?
   a) Ask the other participants to comfort her and invite everybody to make jokes.
   b) Ignore the participant’s tears and continue your session. The next item to be discussed is on comforting and will help her calm down.
   c) Acknowledge the participant’s discomfort, offer her the opportunity to express her concerns or leave the classroom if she wants to, and propose to meet with her for appropriate referrals after the class.
   d) Help the participant leave the room, call her emergency contact and ask him or her to come pick her up.

6) You are leading a prenatal class welcoming 25 future parents. You are discussing the importance of sleep in staying healthy and maintaining wellness when two participants start to argue and take over the discussion. Which of the following is most appropriate?
   a) Immediately walk them out. Where do they think they are?
   b) Gently interrupt the discussion, propose to address specific questions at the end of the class and move on to the next part.
   c) Wait patiently until the discussion dissipates by itself.
   d) Raise your voice and try to talk over them hoping you will get their attention.

7) You are teaching a small group of residents about stress control at a psychological center. The participants are well-engaged in the discussion, and an animated debate focusing on the importance of physical activity is taking place. You suddenly realize that you only have 15 minutes left before the end of the allowed time for the class. You have only covered a fourth of the topic. Which of the following is most appropriate?
   a) Talk as fast as you can to save time. People only remember 10% of the information provided anyway.
   b) Let the participants know the amount of time left and ask them which item they want to focus on.
   c) Cover what you can in the amount of time left and offer handouts and references on the topics that were not discussed.
   d) b & c
   e) None of the above
8) You are invited to teach a nutrition class to a group of high school students. You are very excited about your topic: "How to Increase fruit and vegetable consumption". You have planned to use food models, show a video, and do interactive games with the 20 participants. When you introduce the session half of the students start to sigh and yawn while the others express strong disinterest in the topic. Which of the following is most appropriate?
   a) Ask the participants to express their disinterest and what they feel is unpleasant about the topic; add content and games from there.
   b) Pack up to leave and talk to the coordinator about coming back another day with a more inviting topic.
   c) Ignore their bad mood and go ahead with the topic. Teenagers always disagree with everything anyway!
   d) Negotiate with the students and propose incentives for completing the session.

9) You are invited to talk about the effects of cigarette smoke on the unborn and one's general health in a community center where a free wellness class is organized bi-monthly. You have planned a PowerPoint presentation, an online video document and role-play games in which participants will be divided in groups of five. You had previously visited the classroom and met the technician. When you arrive, the technician tells you that there is no available computer and the Internet connection is down. At the time of the presentation only five people have shown up. Which of the following is most appropriate?
   a) Cancel the class and schedule another session and require the equipment to be set up the way you requested it.
   b) Re-evaluate the onsite equipment available for the day and adjust your presentation to the situation.
   c) Propose to the participants to do the role-play, use handouts and drawings to clarify your teaching.
   d) b only
   e) b & c

10) You are invited to do a presentation in a rehabilitation center on back injuries and ergonomic positions. You plan to use slides and a white board to note participants’ answers. When the participants arrived you noticed that two of them are blind. Which two are most appropriate? (Circle two answers)
   a) Approach them discreetly and tell them that the class setting is not appropriate for them today. Propose to schedule a personal session just for them.
   b) Approach them discreetly; let them know that you are aware of their difference and that you will help them get a good understanding of the topic.
   c) Do nothing different since these people are used to their condition. They will probably let you know if they have any concerns.
   d) After the class, meet with the unit manager to talk about Braille translation and make appropriate referrals.

11) You are asked to lead a parenting class in a rural community while the usual presenter is on vacation. You were told that the group of participants is very diverse but that community health workers would be available to translate and help. Today's participants include people with varying cultural identities, including: Mexican, American Caucasian, African-American, Korean, and Puerto Rican backgrounds. At the time of the class, no community health worker is available. Which of the following is most appropriate?
   a) Do the class in English. After all, we live in the United States and the national language is English.
   b) Cancel the class. You don’t speak any of these languages so you will not be able to communicate with the group.
   c) Evaluate the level of understanding of the participants and use 5th grade level language
   d) Switch to a topic that requires less words and more visual demos such as infant massage, relaxation and breathing techniques.
   e) Two of the above—again. Circle two options.

12) You are invited to participate in a community health fair. As a resource person you will be part of a panel and answer questions about participants' health concerns. On the day of the event, a participant has specific questions about Gaucher, which you are not familiar with. Which of the following is most appropriate?
   a) Tell the participant that you are not really familiar with this condition but will take her contact info after the forum to follow up on her concerns.
   b) Refer her to her primary care physician or specialist to follow up on her condition.
   c) Ask the other panel members if they have any additional information about the disease.
   d) All of the above.

Developed by Nathalie Confiac (February 2011).
APPENDIX K

GROUP TEACHING POST ASSIGNMENT SURVEY

(PAS)
Group Teaching Post Assignment Survey
Nathalie Confiac

Full Name: ________________________________

1) What was the topic of your group teaching assignment?

________________________________________________________________________

2) How many participants attended your group teaching assignment?

________________________________________________________________________

3) In which health care setting did the presentation take place?

________________________________________________________________________

4) What were the characteristics of the participants who attended your group teaching assignment? (language, age range, type of clients)

________________________________________________________________________

5) Was it the first time you were meeting with the participants?

☐ Yes
☐ No

If no, explain how you came to know the participants:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

6) Describe the steps of preparation for your group teaching assignment?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

7) Which teaching method(s) did you use?
8) Did you experience any unexpected situations?
   □ Yes
   □ No
If yes describe the situation in your own words.

9) To what extent did you feel prepared for your group teaching assignment?
   □ Great Extent
   □ Somewhat
   □ Very Little
   □ Not at All

10) To what extent did the role-play activity presented at the workshop help you to feel prepared?
    □ Great Extent
    □ Somewhat
    □ Very Little
    □ Not at All

11) To what extent did the handouts provided at the workshop help you to be prepared?
    □ Great Extent
    □ Somewhat
    □ Very Little
    □ Not at All

12) To what extent did you feel comfortable in implementing your group teaching assignment?
    □ Great Extent
    □ Somewhat
    □ Very Little
    □ Not at All

13) Please add any additional comments you would like to make?

Developed by Nathalie Confiac (February 2011).
APPENDIX L

GROUP TEACHING EXIT SURVEY

(ES)
Full Name: _______________________________

Directions: Answer the following questions. Please use additional paper sheet if necessary

1) Overall what did you think about the workshop?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

2) What did you like best about the workshop?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

3) What was the least helpful/useful portion of the workshop?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

4) What did you think of the format of the workshop?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

5) How did you feel about the theoretical part of the workshop?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

6) What did you think about the information provided regarding learning styles, cultural differences and learners’ motivation?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

120
7) The workshop scenarios discuss unexpected situations such as participants’ potential disinterest to topic, emotional response to topic, cultural challenges and more. What are some other unexpected situations you encountered while doing your assignment or previous professional experience?

8) How did the information and role-play scenarios provided at the workshop modify your practice (way to conduct group teaching)?

9) What other strategies if at all could help you in being better prepared to do group teaching?

10) What other information/topic would you have liked covered in the workshop?

11) The purpose of this Exit survey is to obtain your feedback about the workshop provided, group-teaching assignment following the workshop and your overall experience as nurse educators. We have discussed the information provided during the workshop, your assignment after the workshop and possible ways to be better prepared in doing group teaching to the population we serve. Have we missed anything?

Developed by Nathalie Confiac (February 2011).
APPENDIX M

GROUP TEACHING STUDY TIMELINE
<table>
<thead>
<tr>
<th>Time 1 (May 3-6)</th>
<th>Time 2</th>
<th>Time 3 (June 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 hours</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Activities

**Study Recruitment:**
- Study is described to all students
- Study participants sign the Consent Form and complete the Participant Information Form (PIF)
- Non-participants return declined Consent Form and blank PIF

**Group Teaching Workshop:**
- All students:
  - Complete the pre-test before the workshop
  - Attend the workshop.
  - Complete the post-test after the workshop

Only data collected from the study participants is used.

### Sources of data collection

- Consent Form
- Group Teaching Study Participant Information Form (PIF)
- Group Teaching Pre-test
- Group Teaching Post-test

Group Teaching Assignment:
- All students complete a group teaching assignment.

This is a regular requirement of the course.

### Survey Monkey

- All students complete the Group Teaching Post Assignment Survey (PAS)
- Study participants also complete the Group Teaching Exit Survey (ES)

Instructors are not aware of the participation status of the students

Only the data of the students that elected to participate in the study is used.
APPENDIX N

INSTITUTIONAL REVIEW BOARD APPROVAL LETTER
April 08, 2011

Ms. Natalie Condie
cc: Prof. Teresa Dadd-Butera
Department of Nursing
California State University
5300 University Parkway
San Bernardino, California 92407

Date Ms. Condie:

Your application to use human subjects, titled “Nursing Education: Effectiveness of Group Teaching Workshop in Undergraduate Nursing Students” has been reviewed and approved by the Institutional Review Board (IRB). The attached informed consent document has been stamped and signed by the IRB chairperson. All subsequent requests must be this officially approved version. A change in your informed consent (no matter how minor the change) requires resubmission of your protocol as amended. Your application is approved for one year from April 08, 2011 through April 07, 2012. One month prior to the approval end date you need to file for a renewal if you have not completed your research. See additional requirements Items 1 - 4 of your approval below.

Your responsibilities as the researcher/investigator reporting to the IRB Committee include the following 4 requirements as mandated by the Code of Federal Regulations 45 CFR 46 listed below. Please note that the protocol change form and renewal form are located on the IRB website under the forms menu. Failure to notify the IRB of the above may result in disciplinary action. You are required to keep copies of the informed consent forms and data for at least three years.

1) Submit a protocol change form if any changes (no matter how minor) are made in your research prospective protocol for review and approval if the IRB before implemented in your research.
2) If any unanticipated adverse events are experienced by subjects during your research.
3) If you renew your protocol one month prior to the protocol end date.
4) When your project has ended by emailing the IRB Coordinator/Compliance Analyst

The CSUSB IRB has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval notice does not replace any departmental or additional approvals which may be required.

If you have any questions regarding the IRB decision, please contact Michael Gillespie, IRB Compliance Coordinator, Mr. Michael Gillespie can be reached by phone at (909) 537-7526, by fax at (909) 537-7028, or by email at mgillespie@csusb.edu. Please include your application approval identification number (listed at the top) in all correspondence.

Best of luck with your research.

Sincerely,

[Signature]

Sharen Ward, Ph.D., Chair
Institutional Review Board

cc: Prof. Teresa Dadd-Butera, Department of Nursing
REFERENCES


http://www.nursingworld.org/FunctionalMenuCategories/AboutANA/Honoring-
Nurses/HallofFame/19962000Inductees/hendva5545.aspx


California Nursing Practice Act: Standards of competent Performance California Code of Regulations Title 16, § 1443.5 (2). Retrieved April 17, 2011 from http://leginfo.ca.gov/cgi-bin/waisgate?WAISdocID =13239412684+0+0+0&WAISaction=retrieve


https://www.nln.org/certification/handbook/index.htm


